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## Alcohol problems need more attention in long term opioid substitution treatment

Opioid substitution treatment (OST) using oral methadone and buprenorphine has consistently been shown to substantially reduce illicit heroin use, opioid overdose deaths, and HIV infection and to improve the quality of life of persons who are opioid dependent.<sup>1</sup> OST is usually recommended as a long term maintenance treatment because its benefits are most apparent while patients remain in treatment and they rapidly dissipate when patients withdraw from treatment.<sup>2</sup>

What happens to opioid and other drug use when patients remain in OST for a decade or more?

Marcus Herdener and colleagues answer this question by presenting data on self-reported heroin, cocaine, alcohol and benzodiazepine use in a cohort of 8962 Swiss heroin users who were enrolled in OST over a period of 17 years between 1998 and 2014. There are very few such long term studies of the impact of OST on heroin and other drug use. This is a major gap in the literature given that epidemics of heroin use in many developed countries in the 1990s created an ageing cohort of opioid dependent people, many of whom have remained in OST for several decades.

Some evidence points to increasing rates of problem alcohol use in long term OST patients. An Australian study of mortality in OST patients found increased rates of death from cirrhosis, HCV infection and hepatocellular carcinoma as these patients aged.<sup>3</sup> Similar results have been reported in cohorts in England<sup>4</sup> and Sweden.<sup>5</sup> These mortality patterns point to likely causal roles for high prevalent HBV and HCV infections and heavy alcohol use.

The authors analysed self-reported data on heroin and other drug use that were routinely collected on opioid dependent patients enrolled in OST in the Zurich region of Switzerland. The data are all self-report but such data are generally recognised as reasonably reliable if participants do not have any incentives to under-report.<sup>6</sup> This seems to have been the case in Zurich where continued heroin and cocaine use did not lead to discharge from the program.

Their analyses showed a sharp decline in heroin use on first admission to treatment and a steady decline in frequent heroin (from 14.4% to 6%) and cocaine use (from 8.5% to 4.9%) over the 17 year study period. They also found, as expected, that declines in heroin and cocaine use were associated with improved social integration and there was a decline in social integration if the frequency of heroin or cocaine use increased.

By contrast, the proportion of patients who engaged in frequent alcohol use steadily increased over the study period by the end of which nearly one in four patients (22.5%) were frequent users of alcohol. This probably reflects the greater availability of a cheaper, legal drug like alcohol than heroin or cocaine as opioid dependent persons age.

The authors very reasonably propose that OST programs should make more of an effort to address problem alcohol use by their patients. This is especially relevant given the increased vulnerability of OST patients to liver disease because of their high rates of chronic hepatitis B and C infection. Heavy alcohol use also increases the risks of fatal opioid overdose if it is combined with injecting opioid use.<sup>7</sup>

The fact that many of these patients remain in OST represents an underused opportunity to identify and treat their problem alcohol use. These patients regularly attend the services to receive doses of replacement opioids and so can be readily assessed and counselled. Arguably all patients in OST should be routinely asked about their drinking and those who are drinking heavily advised to cut down the frequency and quantity of their alcohol use.<sup>8</sup> Those who struggle to enact this advice on their own should be offered referral for assessment and interventions such as CBT and pharmacotherapy. As the authors point out, their opioid dependence precludes the use of the opioid antagonists like naltrexone and nalmefene but they can still be offered acamprosate and disulfiram, if this is not contraindicated by compromised liver function or disease.<sup>8</sup>

The impact of long term OST on benzodiazepine use was less clear cut. Regular use remained at low rates but there was a small increase over the study period (10% to 11.1%). This may reflect continued maintenance prescribing of benzodiazepines by OST clinics or general practitioners to avoid patients resorting to the black market for these drugs. This practice also should be evaluated given the poorer social integration of regular benzodiazepine users in this and other cohorts<sup>9</sup> and the increased risks of overdose when opioids are used in combination with benzodiazepines.<sup>7</sup>

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